Kaleidoscope Creative Arts & Science Camp

Leventhal-Sidman Jewish Community Center
333 Nahanton Street, Newton, MA 02459
(617) 558-6523; (617) 244-5124

Health Form

This side to be filled out by parent or guardian.

Name ____ Birthdate ____________ Sex ___ Age ___
Last First M.I.

Parent or Guardian 1 _________________________________ Home Phone__________________________

Parent or Guardian 2 _________________________________ Home Phone__________________________

Home address ____
Street and number City State Zip Code

Parent 1: work phone ______________________________ Cell phone ___________________________

Parent 2 work phone _______________________________ Cell phone ___________________________

Insurance company ________________________________ Policy number ________________________

Emergency Contact:

1. Name ___________________________ Phone #1 ________________ Phone #2__________________

2. Name ___________________________ Phone #1 ________________ Phone #2__________________

HEALTH HISTORY (check and give approximate dates)

Ear infections (since age 5)________
Asthma ________________________
Allergies _______________________
Allergy to Penicillin______________
Hay Fever ______________________
Insect Stings ____________________
Poison Ivy, etc. __________________
Chicken pox __________________
German Measles________________
Measles _______________________
Mumps ________________________
Convulsions ____________________
Diabetes _______________________
Rheumatic fever ________________
Other ____

Chronic or recurring illnesses ____

Food allergies ____

Please list current medications taken at home: ____

List medications to be taken at camp__________________________________ ___________________________

IMPORTANT: Please notify office if this child is exposed to any communicable disease during the three weeks prior to participation.

Parent's Authorization

To the best of my knowledge, this health history is correct. The person herein described has permission to engage in all prescribed physical activities, except as noted by me and the examining physician.

In the event that I cannot be reached in an EMERGENCY, I hereby give permission to the physician selected by the camp directors to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

→ Signature ______________________________ Print Name________________________ Date_______________

MEDICAL EXAMINATION

To be filled out by LICENSED PHYSICIAN

This examination must be performed within 12 months of individual's participation. Examination for some other purpose is acceptable. Examination is for determining fitness to engage in strenuous activities. Physicians may use their own office form in lieu of the questions below.

IMMUNIZATION HISTORY (check and give approximate dates)

DTP series booster ____________________________
Tetanus booster ______________________________
Polio ____
OPV (Sabin) booster ___________________________
Typhoid ____________________________________
Measles vaccine (live) _________________________
Tuberculin test _______________________________
German measles (Rubella) ______________________
Mumps vaccine (live) __________________________
Smallpox ____________________________________
Chicken pox _________________________________
Other _______________________________________

Code:
S – Satisfactory X – not satisfactory (explain) O – not examined

Hgt.________	Wt. ___________	B.P. ______	Hgb. Test ______	Urinalysis_____
Eyes _______	Extremities_____	Glasses____	Posture_________	Ears__________
Skin________	Nose _________	Allergy (please specify)__________		Throat ________
Teeth _______	Heart_________	Lungs ______	Abdomen _______	Hernia ________

Please list all medication taken regularly during this past school year: ______________________________

Recommendations and restrictions while in camp: ____

Special diet: ____

Medication requirements (name and instructions): ____

Swimming: ____

Strenuous activity: ____

Does this child receive any special needs services either privately or at home? _______________________

____

Other: ____

I have examined the person herein described and have reviewed his/her health history. It is my opinion that he/she is physically capable of engaging in physical activities, except as noted above.

Examining physician _______________________________________ Date _________________

Address ____ Phone ________________